

QUARTERLY REPORT

BUREAU OF AUDITS AND INVESTIGATIONS APRIL - JUNE 2009

OFFICE OF THE INSPECTOR GENERAL

STATE OF CALIFORNIA

Introduction

The Office of the Inspector General (OIG) investigates and audits the California Department of Corrections and Rehabilitation (CDCR) to uncover criminal conduct, administrative wrongdoing, poor management practices, waste, fraud, and other abuses. This quarterly report summarizes the OIG's audit and investigation activities for the period of April 1, 2009, through June 30, 2009. The report satisfies the provisions of California Penal Code sections 6129(c)(2) and 6131(c), which require the Inspector General to publish a quarterly summary of investigations completed during the reporting period, including the conduct investigated and any discipline recommended and imposed. To provide a more complete overview of our inspectors' activities and findings, this report also summarizes audit activities, warden and superintendent candidate evaluations, and facility and medical inspections completed during the second quarter of 2009. All the activities reported were carried out under California Penal Code section 6125 et seq., which assigns our office responsibility for independent oversight of CDCR.

Evaluation of Warden and Superintendent Candidates

With the enactment of Senate Bill 737, which took effect on July 1, 2005, the Legislature assigned the Inspector General responsibility for evaluating the qualifications of every candidate the Governor nominates for appointment as a state prison warden. In 2006, California Penal Code section 6126.6 was amended to also require the Governor to submit to the Inspector General the names of youth correctional facility superintendent candidates for review of their qualifications. Within 90 days, the Inspector General advises the Governor on whether the candidate is "exceptionally well-qualified," "well-qualified," "qualified," or "not qualified" for the position. To make the evaluation, California Penal Code section 6126.6 requires the Inspector General to consider, among other factors, the candidate's experience in effectively managing correctional facilities and inmate/ward populations; knowledge of correctional best practices; and ability to deal with employees, the public, inmates, and other interested parties in a fair, effective, and professional manner. Under California Penal Code section 6126.6(e), all communications that pertain to the Inspector General's evaluation of warden and superintendent candidates are absolutely privileged and confidential from disclosure.

During the second quarter of 2009, the Governor submitted three warden candidates to the OIG for evaluation. The OIG completed three warden vettings and submitted the findings to the Governor's Office for final determination.

Facility & Parole Region Inspections

Pursuant to the Budget Act, Senate Bill 77 (Chapter 171, Statutes of 2007), the OIG carries out semi-annual inspections of adult correctional institutions, youth correctional facilities, and the Division of Adult Parole Operations. The inspection program's purpose is for our inspectors to identify fraud, waste and abuse, become more familiar with the institutions and parole operations, develop contacts with staff members, and locate areas needing audit or investigation.

The OIG seeks remedies to detected issues by various means, which include initiating more in-depth audits and investigations, referring matters to the warden or superintendent, or contacting appropriate department managers. When our inspectors identify urgent safety or security issues, we notify the warden, superintendent, or critical management staff before we leave the facility.

For the first and second quarters of 2009, our inspectors visited the following 43 institutions:

- Adelanto Community Correctional Facility
- Avenal State Prison
- California Correctional Center
- California Correctional Institution
- California Institution for Men
- California Institution for Women
- California Medical Facility
- California Men's Colony
- California Rehabilitation Center
- California State Prison, Corcoran
- California State Prison, Los Angeles County
- California State Prison, Sacramento
- California State Prison, San Quentin
- California State Prison, Solano
- California Substance Abuse Treatment Facility and State Prison at Corcoran
- Calipatria State Prison
- Centinela State Prison
- Central California Women's Facility
- Chuckawalla Valley State Prison
- Claremont Custody Center
- Correctional Training Facility
- Desert View Modified Community Correctional Facility
- Deuel Vocational Institution
- Folsom State Prison
- Heman G. Stark Youth Correctional Facility

- High Desert State Prison
- Ironwood State Prison
- Kern Valley State Prison
- Mule Creek State Prison
- N. A. Chaderjian Youth Correctional Facility
- North Kern State Prison
- O. H. Close Youth Correctional Facility
- Pelican Bay State Prison
- Pleasant Valley State Prison
- Preston Youth Correctional Facility/Pine Grove Youth Conservation Camp
- R. J. Donovan Correctional Facility
- Salinas Valley State Prison
- Sierra Conservation Center
- Southern Youth Correctional Reception Center
- Taft Community Correctional Facility
- Tallahatchie County Correctional Facility, MS
- Valley State Prison for Women
- Ventura Youth Correctional Facility/Ventura Youth Conservation Camp
- Wasco State Prison

Also during the first and second quarters of 2009, our inspectors visited eight field offices and all four parole regions.

Summary of Inspection Results

As a result of our facility and parole inspection program during the period of January through June 2009, we thus far have initiated six preliminary investigations, two administrative misconduct investigations, and one review of issues involving potential fraud, waste and abuse. In addition, we referred two investigations involving potential misconduct of staff to the department's Office of Internal Affairs. We are also contacting various prison and health care managers in order to address a variety of lesser issues that may be resolved in a less formal manner.

Medical Inspections

Background

In 2001, California faced a class action lawsuit (*Plata v. Schwarzenegger*, previously *Plata v. Davis*) over the quality of medical care in its prison system. The suit alleged that the state did not protect inmates' Eighth Amendment rights, which prohibit cruel and unusual punishment. In 2002, the parties agreed to several changes designed to improve medical care at the prisons. Subsequently, the federal court established a receivership and stripped the state of its authority to manage medical care operations in the prison system, handing that responsibility to the receiver.

To evaluate and monitor the state's progress in providing medical care to inmates, the receiver requested that the OIG establish an objective, clinically appropriate, and metric-oriented medical inspection program. In response, we developed a program based on the CDCR's policies and procedures; relevant court orders; guidelines developed by the department's Quality Medical Assurance Team and the American Correctional Association; professional literature on correctional medical care; and input from clinical experts, the court, the receiver's office, the department, and the plaintiffs' attorney. This effort resulted in a 21-part medical inspection instrument that we use to evaluate each institution.

The inspection process collects over 1,000 data elements for each institution using up to 162 questions on 21 component areas of medical delivery.

To make the inspection results meaningful to both an expert in medical care and a lay reader, we consulted with clinical experts to create a weighting system that factors the relative importance of each component compared to other components. The result of this weighting ensures that components considered more serious—or those that pose the greatest medical risk to the inmate-patient—are given more weight compared to those considered less serious.

Results

During the second quarter of 2009, the OIG's Medical Inspection Unit issued the results of medical inspections for three institutions: Central California Women's Facility, California Men's Colony, and Sierra Conservation Center. The following schedule summarizes the weighted scores of all institutions inspected and publicly reported as of June 30, 2009.

	California State Prison, Sacramento Report issued	California Medical Facility Report issued	R.J. Donovan Correctional Facility Report issued	Centinela State Prison Report issued	Deuel Vocational Institution Report issued	Central California Women's Facility Report issued	California Men's Colony Report issued	Sierra Conservation Center Report issued	Average Score	Median Score
	Nov 2008 62.7%	Jan 2009 83.6%	Feb 2009 48.8%	Feb 2009 80.9%	Mar 2009 73.5%	May 2009 73.2%	May 2009 57.3%	June 2009 75.0%	69.4%	73.4%
Chronic Care										
Clinical Services	67.0%	87.1%	67.2%	80.1%	72.8%	74.1%	74.2%	71.1%	74.2%	73.5%
Health Screening	76.4%	86.8%	68.0%	77.8%	74.3%	84.3%	73.2%	61.0%	75.2%	75.4%
Specialty Services	47.4%	42.6%	62.3%	59.6%	53.4%	52.6%	63.4%	73.1%	56.8%	56.5%
Urgent Services	82.5%	79.1%	73.2%	80.2%	77.5%	89.4%	83.7%	89.1%	81.8%	81.4%
Emergency Services	47.5%	72.1%	89.7%	76.7%	71.0%	80.1%	85.5%	75.9%	74.8%	76.3%
Prenatal Care/Childbirth/Post- Delivery	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Diagnostic Services	68.1%	72.2%	64.0%	74.4%	73.7%	83.8%	70.0%	85.7%	74.0%	73.0%
Access to Healthcare Information	39.2%	58.8%	44.1%	82.4%	58.8%	53.9%	39.2%	82.4%	57.4%	56.4%
Outpatient Housing Unit	75.6%	85.5%	N/A	N/A	82.8%	N/A	N/A	75.2%	79.8%	79.2%
Internal Reviews	70.4%	68.8%	100.0%	60.8%	93.3%	97.9%	70.4%	60.4%	77.8%	70.4%
Inmate Transfers	75.3%	50.0%	89.5%	100.0%	78.9%	100.0%	94.2%	95.3%	85.4%	91.9%
Clinic Operations	91.0%	82.8%	94.9%	81.8%	87.9%	85.9%	84.8%	87.9%	87.1%	86.9%
Preventive Services	32.1%	43.7%	24.0%	19.0%	21.7%	58.7%	53.0%	28.0%	35.0%	30.1%
Pharmacy Services	74.5%	75.9%	93.3%	57.8%	92.0%	92.0%	90.8%	90.8%	83.4%	90.8%
Other Services*	90.6%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	55.0%	92.1%	100.0%
Inmate Hunger Strikes	10.5%	31.6%	10.5%	31.6%	N/A	100.0%	71.1%	N/A	42.6%	31.6%
Chemical Agent Contraindications	100.0%	86.8%	94.1%	89.4%	89.4%	64.7%	100.0%	100.0%	90.6%	91.8%
Staffing Levels and Training	95.0%	95.0%	100.0%	100.0%	95.0%	85.0%	100.0%	100.0%	96.3%	97.5%
Nursing Policy	78.6%	35.7%	88.6%	71.4%	35.7%	100.0%	78.6%	94.3%	72.9%	78.6%
Overall Score	65.2%	72.4%	68.0%	74.4%	72.6%	77.9%	71.3%	76.1%	72.2%	72.5%

Also during the second quarter of 2009, we performed medical inspections at five institutions for which results were not published during that quarter. The results for California State Prison, Los Angeles County, Pleasant Valley State Prison, and California Correctional Institution were published during the third quarter. The inspection results for California Rehabilitation Center and California Institution for Women will be published during the fourth quarter.

^{*} Other services include the prison's provision of therapeutic diets, its handling of inmates who display poor hygiene, and the availability of the current version of the department's health care services policies and procedures.

Audits

Special Review: California Department of Corrections and Rehabilitation's Office of Internal Affairs Information Security

In May 2009, we issued a special review regarding the security of information systems maintained by CDCR's Office of Internal Affairs (OIA). In this review, we assessed whether OIA took appropriate security measures to protect personal, confidential, and sensitive data from unauthorized access or use and whether the OIA maintained proper accountability for its laptop computers.

We found that OIA violated numerous state rules by not adequately protecting the personal, sensitive, and confidential data stored on its agents' laptop computers. Specifically, 68 percent of OIA's laptop computers tested contained confidential case files for correctional staff members under investigation, including names, addresses, photographs, and criminal allegations. One laptop even contained information from an employee's personnel file.

As a law enforcement entity, it is not unreasonable for OIA agents to have personal, confidential, and sensitive data on their laptops. However, OIA is required by law and regulation to protect such information from unauthorized disclosure. Nevertheless, OIA failed to protect personal, confidential, and sensitive data on its laptops through encryption. Any unauthorized disclosure could jeopardize investigations and potentially subject the state to liability for releasing personal, confidential material.

OIA agents and managers increased the risk of unauthorized access by emailing confidential information to unsecured email addresses. Lastly, we found that OIA did not maintain adequate inventory control over its laptop computers and had several laptops lost or stolen in 2008. These lost laptops likely contained unencrypted personal, confidential, and sensitive data.

We made four recommendations to correct the problems and deficiencies found during the special review.

California Prison Health Care Receivership Corporation's Use of State Funds for Fiscal Year 2007-08

In June 2009, we issued our second report concerning how the California Prison Health Care Receivership Corporation spent state funds to carry out its federal court mandate to oversee California's prison medical system. The review highlights how the receivership spent \$51.2 million in state funds for its operating costs.

By category, the receivership spent \$28.7 million on capital assets, \$13.5 million on professional fees, \$7.3 million on employee compensation and benefits, and \$1.7 million on other expenses and travel. With regard to employee compensation, we noted that eight receivership employees received salaries of \$225,000 or more – equal to or greater than the salary of CDCR's secretary

The review also disclosed that the receivership maintained an average daily balance of \$22 million dollars in commercial bank accounts outside the state treasury. As a result, only \$100,000 of the cash was insured by the Federal Deposit Insurance Corporation, putting virtually all of the money at risk in the event of a bank failure.

We made two recommendations to correct the problems and deficiencies found during the special review.

Special Reports

Special Report: Inmate Cell Phone Use Endangers Prison Security and Public Safety

On May 5, 2009, the OIG released a special report regarding the proliferation of contraband cell phones in California prisons, finding that the unauthorized possession of cell phones and electronic communication devices by inmates is one of the most significant problems facing CDCR.

Inmates' access to cell phones allows them to communicate with their associates inside and outside of prison and to plan prison assaults, plot prison escapes, and orchestrate other illegal activity. Our report reveals that in the last three years, cell phone seizures in state prisons have increased by nearly 1,000 percent. Those responsible for this smuggling activity include: staff, visitors, outside accomplices, minimum support facility inmates working outside perimeter fences, and contract employees.

The introduction and possession of cell phones in state prisons is a lowrisk, high-reward endeavor because there are currently no criminal consequences, making this activity merely an administrative violation.

Our report also disclosed that the department's current security entrance procedures are largely ineffective in keeping cell phones out of its prisons. As a result, staff and visitors bring contraband into prisons without fear of discovery.

The department must strengthen its security screening of staff and visitors entering its prisons to deter and detect cell phones. We made nine recommendations to help the department address the problem of cell phones in California's prisons.

Intake and Investigations

The OIG received 847 complaints this quarter concerning the state correctional system, an average of 282 complaints a month. Most complaints arrive by mail or through the Inspector General's 24-hour toll-free telephone line. Others are brought to our attention during audits or related investigations. We may also conduct investigations at the request of CDCR officials in cases that involve potential conflicts of interest or misconduct by high-level administrators.

Our staff responds to each complaint or request for investigation; complaints that involve urgent health and safety issues receive priority attention. Most often, our staff resolves the complaints at a preliminary stage through informal inquiry by contacting the complainant and the institution or division involved to either establish that the complaint is unwarranted or to bring about an informal remedy.

Depending on the circumstances surrounding a complaint, we may refer cases to CDCR's Office of Internal Affairs (OIA) for investigation. Cases referred to the OIA may be monitored by OIG's Bureau of Independent Review (BIR) if they meet applicable criteria. The BIR reports its monitoring activities semiannually in a separate report.

Some allegations or incidents require preliminary or full investigation by the OIG. In addition to large-scale investigations, the OIG initiates routine preliminary investigations into critical incidents occurring within CDCR, such as inmate deaths, civilian homicides committed by parolees, civil rights violations, and major security concerns occurring in the department. When the OIG identifies a critical incident, a preliminary investigation is conducted to identify any misconduct by staff or inmates, potential policy violations, or systemic issues that may warrant further action by the OIG. During the second quarter of 2009, the Bureau of Audits and Investigations had 132 ongoing investigations and completed two administrative investigations and thirteen preliminary investigations. Those completed investigations are summarized in the table that follows.

Allegation/Incident	Investigation	Result
The OIG received a complaint alleging that CDCR correctional officers had committed various acts of misconduct including allowing inmates to participate in wrestling matches with each other, providing contraband to inmates, allowing and participating in gambling with inmates, and allowing certain inmates to have additional freedom of movement throughout the prison.	The OIG conducted an administrative investigation that included interviews of departmental staff and inmates and the collection and review of documents.	The investigation found no evidence to support the allegations. The OIG closed this investigation.
The OIG received a complaint alleging that CDCR management staff and correctional staff supervisors released confidential information regarding an investigation concerning staff misconduct.	The OIG conducted an administrative investigation that included interviews of departmental staff and inmates and the collection and review of documents.	The investigation found no evidence to support the allegations. The OIG closed this investigation.
The OIG received information alleging that prison maintenance employees were manipulating CDCR's overtime policy.	The OIG conducted preliminary investigation that included contact with prison staff and the review of maintenance workers' time sheets.	The preliminary investigation found no evidence to support the allegations or warrant an administrative investigation. The OIG closed this investigation.
The OIG initiated a routine preliminary investigation into the circumstances surrounding the Division of Parole Operations' supervision of a parolee suspected of murdering two adults and two children before killing himself.	The OIG conducted a preliminary investigation that included reviews of parole documents and classification data.	The preliminary investigation found that the parole agents supervised the parolee according to policy. The OIG closed this investigation.
The OIG initiated a routine preliminary investigation into circumstances surrounding an inmate who committed suicide in October 2008, while housed in a Sensitive Needs Yard facility.	The OIG conducted a preliminary investigation that included interviews with staff and inmates, and review of the incident report, the inmate's central file, pertinent logs, and other documents.	The preliminary investigation determined staff followed procedures in relation to suicide prevention and emergency response to the incident. However, the investigation revealed issues related to inmate movement accountability and inmate worker timekeeping. The OIG referred the additional findings to CDCR for follow-up and closed this investigation.
The OIG received information that a correctional officer sustained a suspicious head injury in a prison's parking lot while walking to his/her vehicle.	The OIG conducted a routine preliminary investigation that included a review of the circumstances of the accident and contact with prison staff.	The preliminary investigation found no foul play or safety issues in regard to the officer's injury that would warrant further review. The OIG closed this investigation.

Allegation/Incident	Investigation	Result		
The OIG received information indicating that contraband, including cell phones, was discovered in a package addressed to an inmate. Based upon the initial information received, the OIG determined the discovery may present a major security breach for the introduction of contraband into the prison.	The OIG conducted a routine preliminary investigation that included contact with the institution and review of reports and documents.	The preliminary investigation found that the incident did not constitute a major security breach. The OIG closed this investigation.		
The OIG received information alleging the alteration of requirements on a Request for Proposal for construction after it was issued, making the process biased and unequal for all of the competing bidders.	The OIG conducted a preliminary investigation that included contact with staff, the complainant, and the review of policies, procedures, and laws. Further, the Request for Proposal was examined.	The preliminary investigation found no evidence to support the allegations or warrant an administrative investigation. The OIG closed this investigation.		
The OIG initiated a routine preliminary investigation into the in-cell homicide of an inmate by another inmate in the administrative segregation unit at a California state prison.	The OIG conducted a site visit of the prison and reviewed inmate records, departmental policy, state regulations, prison investigative reports, and the coroner's report.	The preliminary investigation found no evidence that the inmates were inappropriately housed together or inadequately supervised. The OIG closed this investigation. Criminal prosecution based upon the prison's investigation is pending with the local district attorney's office.		
The OIG received information alleging custody officer overtime was not being assigned efficiently, which resulted in an increased cost at a California state prison.	The OIG conducted a preliminary investigation that included interviews with prison staff and a review of overtime allocation practices.	The preliminary investigation found that institution management had already addressed overtime cost issues. The OIG closed this investigation.		
The OIG initiated a preliminary investigation into the Division of Parole Operations' supervision of a parolee. The parolee was suspected of raping a woman with the use of a date rape drug.	The OIG conducted a preliminary investigation that included the review of parole supervision documents and classification data.	The preliminary investigation found that the parole agents supervised the parolee within the parameters established by policy. The OIG closed this investigation.		
The OIG received information alleging that the California Prison Health Care Receivership (CPHCR) violated the Public Contract Code in awarding a contract.	The OIG conducted a preliminary investigation that included a review of pertinent Public Contract Code sections, CDCR Request for Proposal, proposal responses, and a federal court order permitting the CPHCR to waive state contracting law, with respect to the specific project.	The preliminary investigation found no evidence to support wrongdoing by the CPHCR. The OIG closed this investigation.		
The OIG identified information that four separate riots occurred at a California state prison between February 21 and April 14, 2009, involving African American and Hispanic inmates.	The OIG conducted a routine preliminary investigation that included interviews of staff, and the review of documents.	The preliminary investigation found no issues regarding staff's actions to warrant further investigation The OIG closed this investigation.		

Allegation/Incident	Investigation	Result
The OIG initiated a routine preliminary investigation into Division of Parole Operations supervision of a parolee suspected of murdering a civilian.	The OIG conducted a preliminary investigation that included a review of parole records, crime/incident reports, investigative reports, departmental policy, and state regulations.	The police investigation found that the parolee was mistakenly identified as a suspect and was not actually involved in the incident. The OIG found no violations of departmental policies, procedures, or state regulations. The OIG closed this investigation.
The OIG conducted a preliminary investigation into the circumstances surrounding an inmate suicide committed in March 2009, while housed in a Sensitive Needs Yard facility.	The OIG conducted a routine preliminary investigation that included interviews with staff and inmates, and a review of the incident report, the inmate's central file, pertinent logs, and other documents.	The preliminary investigation found no evidence to indicate staff misconduct related to suicide prevention and incident response. However, the investigation revealed issues related to inmate worker timekeeping. The OIG closed this investigation and referred the information to CDCR for follow-up.